STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235396	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Silverbell Estates	1255 West Silverbell Road Orion, MI 48359

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2737537. Based on interview and record review, the facility failed to honor an advanced directive for one resident (R902) of one resident reviewed for code status/advanced directives, resulting in five rounds of CRP/chest compressions (Cardiopulmonary Resuscitation) being performed against their wishes and subsequent emergency transfer to an acute care hospital. Findings include:On [DATE] a concern submitted to the State Agency (SA) was reviewed which alleged the facility did not honor a residents' advanced directive/code status.On [DATE] at 10:59 a.m., during an interview with the Director of Nursing (DON), the DON was queried if the facility had completed any recent CPR/Code events on any younger male residents in the facility, and they reported that R902 had a Code Blue ran on them in late January/early February.On [DATE] at approximately 11:05 a.m., The DON was queried regarding R902's CPR event on [DATE] and they reported they had identified some issues with the process of administering CPR to R902. The DON reported the Nursing staff that had performed CPR on R902 had failed to check R902's advanced directive and that after review of the event, R902 had signed a DNR (Do-not resuscitate) form and should not have had CPR performed on them. On [DATE] the medical record for R902 was reviewed and revealed the following: R902 was initially admitted to the facility on [DATE] and had diagnoses including Osteomyelitis of Left hand and Major depressive disorder [recurrent].A facility document titled Code Status-Elective Form that was signed by R902 and their attending Physician on [DATE] revealed the following: [checked] Do Not Resuscitate-(No Code) Code Status: DNR-Do not attempt resuscitation.Do-Not-Resuscitate Order. I have discussed my health status with my Physician.I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order is in effect until it revoked by me. Being of sound mind, I voluntarily execute this order, and I understand its full import.A Physician's order dated [DATE] revealed the following: Advance Directive: DNRA Social service evaluation dated [DATE] revealed the following: 8. Does the resident have advanced directives? [Yes].If yes, check all that apply: G. DNR.Are copies of the Advanced Directive in the resident's chart? 12. [Yes].An incident/accident note dated [DATE] at 23:20 revealed the following: Resident found unresponsive on bathroom floor. No respirations and no palpable pulse noted. Pipe and cigarette lighter observed on bathroom floor next to resident; substance unknown. Code Blue initiated. CPR started immediately by staff at 23:03. Five rounds of CPR completed. Resident regained spontaneous respirations and palpable pulse prior to EMS (Emergency Medical System) arrival. Oxygen applied per protocol. Resident remained unresponsive but breathing spontaneously. EMS arrived and assumed care. Resident transferred out of facility for higher level of care.On [DATE] at approximately 11:45 a.m., Nurse Supervisor G (NS G) was interviewed regarding the Code Blue that was conducted on R902 on [DATE]. They reported that R902 had been found in the bathroom and was unresponsive with no pulse and no respirations. NS G reported they had performed CPR on R902 as a result. NS (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G was asked if the Nurses that performed CPR had verified R902's code status before starting it and they reported they did not because they had thought that R902's Nurse had previously verified it. NS G reported it was the Nursing standard to quickly verify code status of a resident before starting CPR. NS G reported they gave five rounds of chest compressions to R902 in which R902 regained a pulse and the code was transferred to EMS when they arrived. On [DATE] at approximately 12:35 p.m., Social Service Director G was asked if they had discussed advanced directives with R902 during their initial assessment and they reported they had and that R902 had stated they wanted to have a code status of DNR because it was their choice and that's what they were in the hospital. SSD G was asked if they had explained that DNR means to R902 and they reported they had.On [DATE] at approximately 12:58 p.m., Nurse I was queried regarding the Code Blue conducted on R902. They reported they were R902's Nurse at that time but did not perform any CPR on them. They reported that Nurse G had performed the CPR on R902. Nurse I was asked if they had verified R902's code status before the Nursing team had started CPR and they reported they had not and that they had learned later that R902 was a DNR and CPR should not have been performed. On [DATE] at approximately 2:24 p.m., during a conversation with the Director of Nursing (DON) the DON was queried regarding the Past Non-Compliance pertaining to R902's Code Blue and they reported that all Nurses had been in-serviced on the appropriate steps to take when a resident is found unresponsive including checking the advanced directives of the resident. The DON Stated the management had audited the faculty's medical records and corrected any inconsistencies with Advanced Directives and that chart audits were ongoing.A facility document titled Coaching/Corrective Action document for NS G dated [DATE] revealed the following: Written Warning .Reasons [Job Performance] .Details of Offense-Staff failed to acknowledge resident correct advance directive code status .A facility document titled Advanced Directives was reviewed and revealed the following: Policy Statement-Advance directives will be respected in accordance with the state law and facility policy .10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive .A secondary document titled Advance Directive revealed the following: It is extremely important to know the patients code status or advanced directives before administering CPR. If a patient is unresponsive without a pulse, please check for code status before initiating CPR. If that patient is without a pulse and is DNR, do not perform CPR. Alert management and authorities to your findings. If that patient is a full code or allows for CPR, please initiate compressions immediately. Nurses, please lean who your DNR residents are at that start of your shift to prevent having to wait for someone to look through the chart before you can start CPR. Please respect the patient's wishes. this is a legal document .During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included.Nursing education on advanced directives and a facility audit on advanced directives in all resident charts. The facility was able to demonstrate monitoring of the corrective action and maintained compliance